

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13794
13798
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b about 50 yrs			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital				d. STREET ADDRESS 708 Church Street			
3. NAME OF DECEASED (Type or print) First CECIL Middle KEENE Last APPLEGARTH				4. DATE OF DEATH Month Oct. Day 1, Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1892 Sept. 15, 1922	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elec Appliance Sales				10b. KIND OF BUSINESS OR INDUSTRY Retail Merchant		11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William F. Applegarth				14. MOTHER'S MAIDEN NAME Annette Keene			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unk				16. SOCIAL SECURITY NO. unk		17. INFORMANT Harold G. Applegarth, Cambridge, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subtotal gastric resection for benign ulcer Sept 22, 1967						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Aug , 19 67 to Oct 1 , 19 67 , that (I) (we) last saw the deceased alive on Oct 1 , 19 67 , and that death occurred at 9 M, from the causes and on the date stated above.							
22a. SIGNATURE Lewis M. Burdette						22b. DATE SIGNED 30 Oct 67	
22c. PHYSICIAN'S NAME (Type) Lewis M. Burdette						22d. ADDRESS 4 Aurora St. Cambridge Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 4, 1967		23c. NAME OF CEMETERY OR CREMATORY Star Of The Sea Cemetery		23d. LOCATION (City, town or county) (State) Golden Hill, Dor. Co., Md.	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland				25a. REC'D BY REGISTRAR OCT 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (B)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13795

13799

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Cambridge Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HAROLD Middle PIERRE Last APPLEGARTH		4. DATE OF DEATH Month Oct. Day 26 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1925
9. AGE (In years lost birthday) 41 yrs.		IF UNDER 1 YEAR Months 41 Days 19 Hours 67 Min.	IF UNDER 24 HRS. Months 41 Days 19 Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harold G. Applegarth		14. MOTHER'S MAIDEN NAME Imogene Seward	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Harold G. Applegarth, Cambridge, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-Cranial injury DUE TO (b) Multiple skull fractures DUE TO (c) - - - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH Instant Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Riding bicycle, head on collision with auto.	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 7 PM p.m. 10/26/67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) (County) (State) Cambridge, Dor. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		22. DATE SIGNED 10/27/67	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		Address (Street, city, town, or county) Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct 30, 1967	23c. NAME OF CEMETERY OR CREMATORY Star Of The Sea Cemetery	23d. LOCATION (City or Town) (County) (State) Golden Hill, Dor. Co. Md
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR OCT 30 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

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REPORT ON THE PROGRESS OF THE WORK

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div> <div>13796</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div>CERTIFICATE OF DEATH</div> <div>13800</div> </div>																				
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b <u>1 month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge-Maryland Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> d. STREET ADDRESS <u>107 Somerset Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Raymond</u> <u>T.</u> <u>Applegarth</u>			4. DATE OF DEATH <u>Oct. 21, 1967</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
8. DATE OF BIRTH <u>Aug. 26, 1886</u>			9. AGE (In years last birthday) <u>81</u> yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>County tax assessor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Cambridge, R.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.																		
Months	Days	Hours	Min.																	
13. FATHER'S NAME <u>Thomas S. Applegarth</u>					14. MOTHER'S MAIDEN NAME <u>Ettie M. Bennett</u>															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT <u>Mrs. Eva C. Applegarth, Cambridge, Md.</u>										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493x</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST, DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bleeding duodenal ulcer - Uremia</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1, 1967</u> , to <u>Oct 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 20, 1967</u> , and that death occurred <u>2:45 PM</u> from the causes and on the date stated above.																				
22a. SIGNATURE <u>Lewis M. Burdette</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Oct 21, 1967</u>												
22c. PHYSICIAN'S NAME (Type) <u>Lewis M. Burdette</u>						22d. ADDRESS <u>4 Aurora St, Cambridge Md</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Oct. 23, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park, Cambridge, Md.</u>			23d. LOCATION (City, town or county) (State)												
24. FUNERAL DIRECTOR <u>Samuel A. Thomas</u> ADDRESS <u>Cambridge, Md.</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>												
DATE <u>OCT 26 1967</u>																				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13801											
PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 2 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Maryland Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 205 Washington St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First John Middle Jacob Last Arnie			4. DATE OF DEATH Month Oct. Day 24 Year 1967			5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH August 10, 1885			9. AGE (In years last birthday) 82 yrs.			IF UNDER 1 YEAR: Months 09 Days 1 IF UNDER 24 HRS: Hours 09 Min. 1		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Merchant			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Monroe, Wisconsin			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME John J. Arnie					14. MOTHER'S MAIDEN NAME Sophia Beyer						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 219-36-6751			17. INFORMANT Mrs. Grace M. Arnie, Cambridge, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Hemorrhage 331X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____											
21. I certify that (I) (this hospital) attended the deceased from 10-23 , 19 67 , to 10-24 , 19 67 , that (I) (we) last saw the deceased alive on 10-24 , 19 67 , and that death occurred at 3:30 PM , from the causes and on the date stated above.											
22a. SIGNATURE [Signature] 22c. PHYSICIAN'S NAME (Type) _____					22b. DATE SIGNED 10-26-67 22d. ADDRESS _____						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Oct. 27, 1967			23c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery			23d. LOCATION (City, town or county) (State) East New Market, Md.		
24. FUNERAL DIRECTOR Kenneth R. Thomas ADDRESS Cambridge, Md.					25a. REC'D BY REGISTRAR NOV 3 1967 25b. REGISTRAR'S SIGNATURE [Signature]						

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CERTIFICATE OF DEATH

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13799

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Brookview		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERTA Middle V. Last BELL		4. DATE OF DEATH Month October Day 15 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 30, 1877
9. AGE (In years lost birthday) yrs. 90		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	
11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James C. D. Adams		14. MOTHER'S MAIDEN NAME Josephine Willey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT J. Peyton Adams, Rhodesdale, Md., RFD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Renal DUE TO General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1966 , to Oct 15, 1967 , that (I) (we) last saw the deceased alive on Oct 14, 1967 , and that death occurred at 4 P. M. from causes and on the date stated above.			
22a. SIGNATURE H.S. Kuhlman		22b. DATE SIGNED 10/17/67	
22c. PHYSICIAN'S NAME (Type) H.S. Kuhlman		22d. ADDRESS Sharpton Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 17, 1967	23c. NAME OF CEMETERY OR CREMATORY Brookview Cemetery	23d. LOCATION (City or Town) (County) (State) Brookview, Maryland
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR DATE OCT 23 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECORDS OF THE

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Records - 1941

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RECORDS OF THE
DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C.
1941

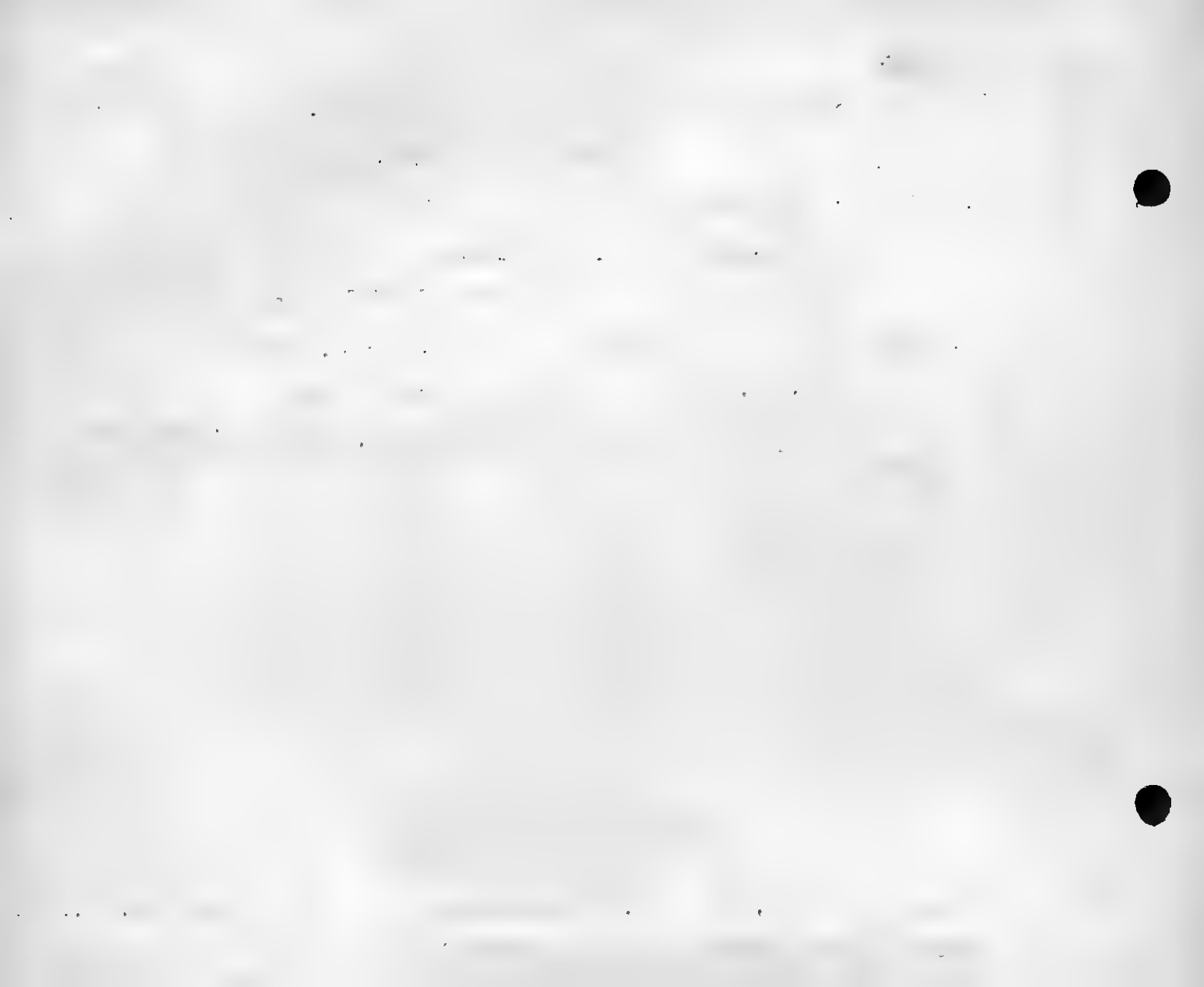
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

13804

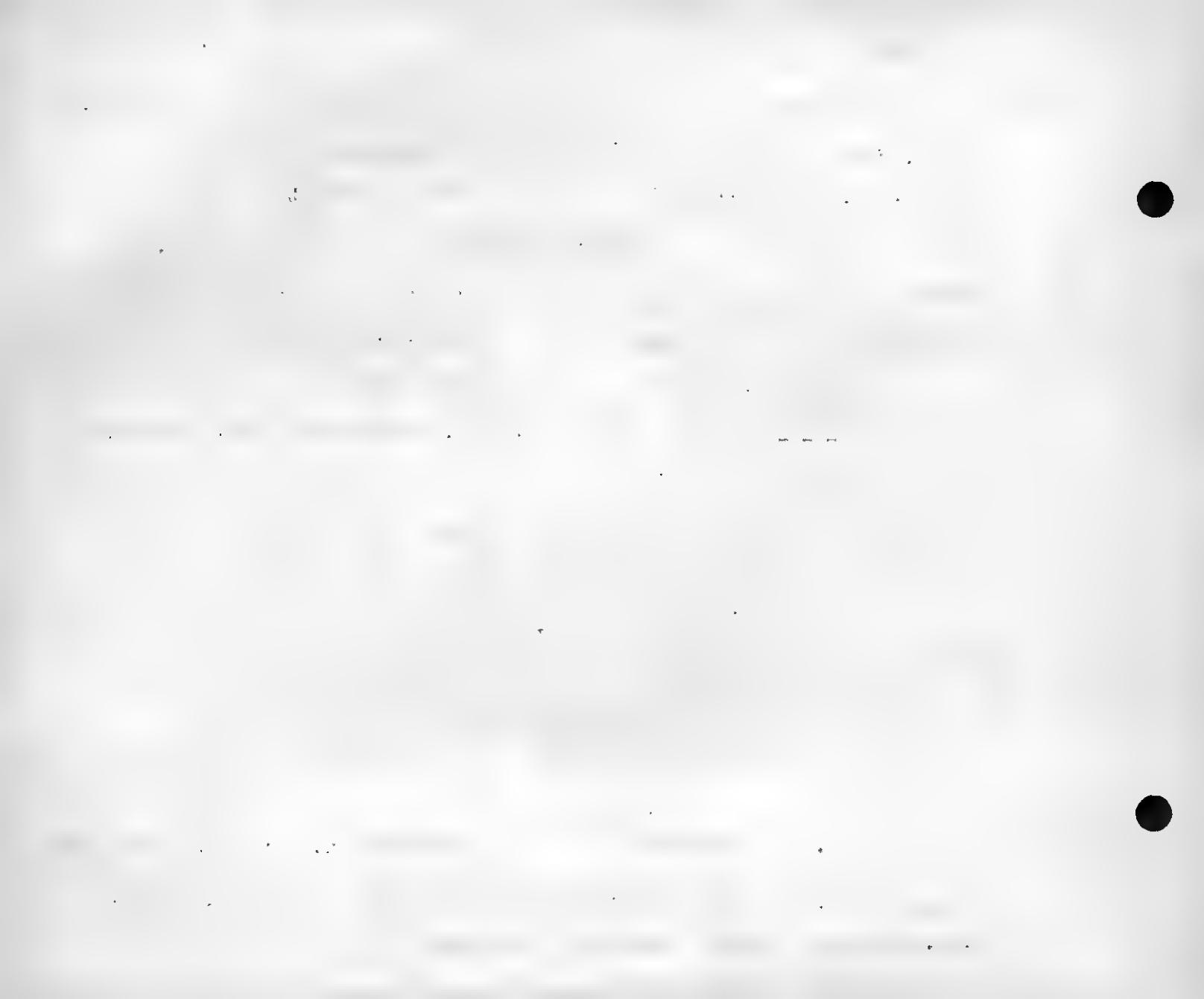
1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN ID 1 month	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital			
3. NAME OF DECEASED (Type or print) HERBERT		4. DATE OF DEATH Month Oct. 5, Day 1967	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 11, 1891	
9. AGE (in years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Moses W. Bramble		14. MOTHER'S MAIDEN NAME Minnie Dayton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Mrs. Herbert C. Bramble, Bishops Head, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG - METASTASES TO ADRENAL DUE TO (b) 10-5-8 DUE TO (c) 10-5-8 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 9-8, 1967 , to 10-5, 1967 , that (2) (we) last saw the deceased alive on 10-5, 1967 , and that death occurred at 7:30 p.m. from the causes and on the date stated above.			
22a. SIGNATURE James F. McCarter		22b. DATE SIGNED 10-7-67	
22c. PHYSICIAN'S NAME (Type) JAMES F. MCCARTER, M.D.		22d. ADDRESS Box 386 Cambridge, Md. 21613	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 8, 1967	
23c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery		23d. LOCATION (City, town or county) (State) Bishops Head, Dor. Co., Md.	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR OCT 16 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		25c. DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ADA Middle V. ASPLEN Last BROHAWN		4. DATE OF DEATH Month Oct. Day 5 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 31, 1885
9. AGE (in years last birthday) 81 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Otho J. Asplen		14. MOTHER'S MAIDEN NAME Ada Bennett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unk	
17. INFORMANT John J. Brohawn, Cambridge, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Branchial Aneurysm			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-30, 1967 to 10-5, 1967 , that (I) (we) last saw the deceased alive on 10-5, 1967 , and that death occurred at 2:30 P.M. from the causes and on the date stated above			
22a. SIGNATURE W. N. Baumann		22b. DATE SIGNED 10-6-67	
22c. PHYSICIAN'S NAME (Type) W. N. Baumann, MD		22d. ADDRESS 10 Aurora St., Cambridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct 7, 1967	23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park	23d. LOCATION (City, town or county) (State) Cambridge, Maryland
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR OCT 16 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13801

13806

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Md. b. COUNTY CAROLINE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE		c. LENGTH OF STAY IN 1b 2 YEARS		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) MARYDEL			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES WILMER CAIN				4. DATE OF DEATH Month OCT. Day 5 Year 19 67			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/3/70	9. AGE (In years last birthday) 97 yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agricul.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elijah Cain				14. MOTHER'S MAIDEN NAME Harriett Pierce			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no no		16. SOCIAL SECURITY NO. 220-52-7907T		17. INFORMANT HOSPITAL RECORDS Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 491X Bilateral bronchopneumonia DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Nephrosclerosis - Uremia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. [City or town] (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 5, 1965 to October 5, 1967 , that (I) (we) last saw the deceased alive on Oct 5 19 67 , and that death occurred at 3:20 P.M. from causes and on the date stated above.							
22a. SIGNATURE Carlos F Barros M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED October 5, 1967	
22c. PHYSICIAN'S NAME (Type) CARLOS F BARROSO				22d. ADDRESS HURLOCK Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-9-67		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION (City or Town) (County) (State) Marydel, Md.	
24. FUNERAL DIRECTOR Lward C Stevenson ADDRESS Luxmore				25a. REC'D BY REGISTRAR OCT 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13802

CERTIFICATE OF DEATH

13807

1 PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HURLOCK		c. LENGTH OF STAY IN 1b 4 MONTHS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BELLE HAVEN NURSING HOME		d. STREET ADDRESS OLD DENTON ROAD	
3 NAME OF DECEASED (Type or print) First MATTIE Middle DOUGHTY Last CHRISTOPHER		4 DATE OF DEATH Month OCTOBER Day 17 Year 67	
5 SEX FEMALE	6. COLOR OR RACE CAU.	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH SEPT. 17, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY HOME	9 AGE (In years last birthday) yrs 80 IF UNDER 1 YEAR Months Days Hours Min.
11 BIRTHPLACE (County & State, or foreign country) CAROLINE COUNTY, MARYLAND		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY F. ANDREW		14. MOTHER'S MAIDEN NAME A. VICTORIA JESTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-20-6832	
17. INFORMANT MRS. G. W. FLUHARTY, FEDERALSBURG, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic cardiac Decompensation DUE TO (b) Arteriosclerotic Cardio Renal Disease DUE TO (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 10yrs 20yrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral cataracts Osteoarthritis			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/17 , 19 67 , to 10/17/67 , that (I) (we) last saw the deceased alive on 10/13/67 , 19 67 , and that death occurred at 2:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Harold B. Plummer M.D.		22b. DATE SIGNED 10/26/67	
22c. PHYSICIAN'S NAME (Type) Harold B. Plummer M.D.		22d. ADDRESS Preston Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF OCT. 21, '67	23c. NAME OF CEMETERY OR CREMATORY HILL CREST CEMETERY	23d. LOCATION (City or Town) (County) (State) FEDERALSBURG, CAROLINE, MD.
24. FUNERAL DIRECTOR FRAMPTON FUNERAL HOME, FEDERALSBURG, MD.		25a. REC'D BY REGISTRAR NOV 2 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY Dorchester MARYLAND						2 USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE Maryland b. COUNTY Dorchester					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylor's Island					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital (DOA)						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) William A. Cornish						4 DATE OF DEATH Oct. 11, 1967		Month Oct. Day 11 Year 1967			
5 SEX Male		6 COLOR OR RACE Negro		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH June 1, 1898		9 AGE (In years lost birthday) yrs 69		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland				12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Alexander Cornish						14 MOTHER'S MAIDEN NAME Leah James					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16 SOC. A. SECURITY NO. 218-05-1595		17 INFORMANT Maggie Bennett Taylor's Island, Md. Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____										INTERVAL BETWEEN ONSET AND DEATH 15 Mins	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John Mace Jr. M.D.						22. DATE SIGNED 10/13/67 Cambridge, Md.					
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/15/67		23c. NAME OF CEMETERY OR CREMATORY Taylor's Island		23d. LOCATION (City or Town) (County) (State) Dorchester County, Md.			
24. FUNERAL DIRECTOR Frederick C. Jones Cambridge, Md.						25a. REC'D BY REGISTRAR DATE OCT 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

1. FURNACE INSTRUCTIONS: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

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13804

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13809

1 PLACE OF DEATH a COUNTY Dorchester MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if inst. l.t. on Residence before admision) a STATE Maryland b COUNTY Dorchester	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c LENGTH OF STAY IN TB Cambridge	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 906 Phillips St.		d STREET ADDRESS 906 Phillips St.	
3 NAME OF DECEASED (Type or print) Thomas L. Davis		4 DATE OF DEATH Month Oct. Day 27 Year 1967	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 1900 67 yrs
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		9b FINDER 1 YEAR Months 27 Days 19 Hours 67 Min	
10b KIND OF BUSINESS OR INDUSTRY farm		11 BIRTHPLACE (State or foreign country) VA	
13 FATHER'S NAME THOMAS O. DAVIS		14 MOTHER'S MAIDEN NAME ELEANOR VAUGHAN	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOC. A. SECURITY NO. 218-01-8010	
17 INFORMANT PETER DAVIS		Address RT 1 EMPIRIA, VA	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of bladder DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 9	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		22. DATE SIGNED 11/11/67	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		Address (Street, city, town or county) Cambridge, Md.	
23a BURIAL (CREMATION REMOVAL Specify) Removal - Burial		23b DATE THEREOF 10-31-67	
23c NAME OF CEMETERY OR CREMATORIUM Willow Hill		23d LOCATION (City or town) (County) (State) Emporia Va	
24 FUNERAL DIRECTOR Willie West		25a REC'D BY REGISTRAR Society Inc	
25b REGISTRAR'S SIGNATURE John Mace Jr.		DATE OCT 31 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock	c. LENGTH OF STAY IN TB 2 mons. 19 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Belle Haven Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IVY Middle BEATRICE Last EGE		4. DATE OF DEATH Month October Day 8 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1887
9. AGE (In years last birthday) yrs 80		IF UNDER 1 YEAR Months 8 Days 19 Hours 67 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Harrisburg, Penna.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Adam Kope	
14. MOTHER'S MAIDEN NAME Elizabeth McLenagan		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Nursing Home Records, Hurlock, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO (b) Massive Cerebral Hemorrhage DUE TO (c) Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVA. BETWEEN ONSET AND DEATH 1-2 HRS 60hrs 15yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/12/67 , 19 67 to 10/8 , 19 67 , that (I) (we) lost saw the deceased alive on 10/8 , 19 67 , and that death occurred at 2:55 AM from causes on and on the date stated above			
22a. SIGNATURE <i>Harold B. Pummer</i>		22b. DATE SIGNED 10/8/67	
22c. PHYSICIAN'S NAME (Type) Harold B. Pummer M.D.		22d. ADDRESS Preston Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 10, 1967	23c. NAME OF CEMETERY OR CREMATORY Silverbrook Cemetery	23d. LOCATION (City or Town) (County) (State) Wilmington, Delaware
24. FUNERAL DIRECTOR <i>J. J. Frampton and Son</i>		25a. REC'D BY REGISTRAR OCT 10 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

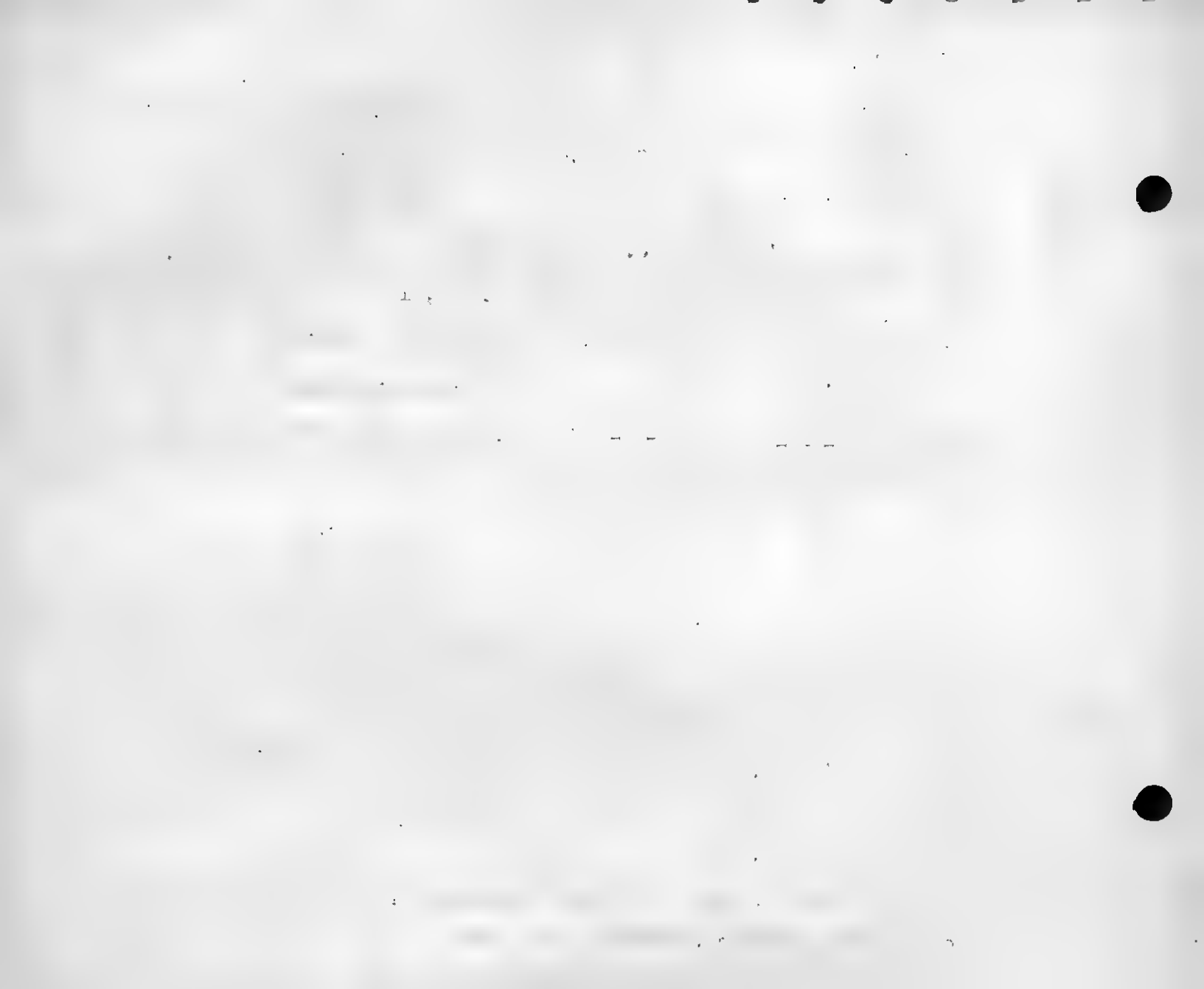
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13811

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock c. LENGTH OF STAY IN 1b 3 1/2 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Belle Haven Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS Academy Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First D'ARCY Middle J. Last FOUNTAIN		4. DATE OF DEATH Month Oct. Day 9, Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 29, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk		10b. KIND OF BUSINESS OR INDUSTRY Retail Store	11. BIRTHPLACE (County & State, or foreign country) Cambridge, Maryland
13. FATHER'S NAME John A. Fountain		14. MOTHER'S MAIDEN NAME Wilhelmina Mills	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO. 220-07-5261	
17. INFORMANT Mrs. William Shaw, Cambridge, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary Edema DUE TO (b) Chronic Congestive cardiac renal Disease DUE TO (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 days 3 mos 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Barin Syndrome			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/17.64 , 19 to 10/9/67 , 19, that (I) (we) last saw the deceased alive on 10/8/67 , 19, and that death occurred at 2:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 10/11/67	
22c. PHYSICIAN'S NAME (Type) Harold B. Blummer M.D.		22d. ADDRESS Preston Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct 11, 1967	23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park	23d. LOCATION (City, town or county) (State) Cambridge, Maryland
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR 10/16/67 25b. REGISTRAR'S SIGNATURE [Signature]	
ADDRESS		DATE	



CERTIFICATE OF DEATH

13812

13807

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wic</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>2 yrs 5 mo 3</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp</u>				d STREET ADDRESS <u>407 N. Division St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>John Stephen Gates</u>				4. DATE OF DEATH Month <u>10</u> Day <u>11</u> Year <u>1967</u>			
5. SEX <u>m</u>	6. COLOR OF RACE <u>w</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03-15-86</u>	9 AGE (In years last birthday) yrs. <u>81</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCH MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CITY OF SALISBURY</u>		11 BIRTHPLACE (County & State or foreign country) <u>Vermont</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Arthur Gates</u>				14 MOTHER'S MAIDEN NAME <u>Martha Gates</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO <u>UNKNOWN</u>		17. INFORMANT <u>Records</u> Address <u>E. S. S. H.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4341 Congestive heart failure</u> DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, Diabetic mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 3</u> , 19 <u>65</u> , to <u>October 11</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>October 11</u> , 19 <u>67</u> , and that death occurred at <u>120</u> p.m., from causes and on the date stated above.							
22a. SIGNATURE <u>Carlos F Barrero</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>October 11, 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CARLOS F BARRERO</u>				22d. ADDRESS <u>HURLOCK, Md.</u>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/14/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARSONS Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>SALISBURY, Wic. Md.</u>	
24. FUNERAL DIRECTOR <u>Hill Funeral Home Salisbury, Md.</u> <u>Norman T. Balow</u>				25a. REC'D BY REGISTRAR <u>OCT 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13802

13813

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO		
b. CITY OR TOWN (If outside corporate limits, write RURAL or name of place) CAMERON		c. LENGTH OF STAY IN 1b 7 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARSONSBURG (Rural)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL			d. STREET ADDRESS ROUTE 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CLIFFORD DAE GILLIS			4. DATE OF DEATH Month Day Year OCTOBER 7 1967		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08-16-94	9. AGE (In years lost birthday) yrs 73	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (County & State, or foreign country) WICOMICO, MARYLAND	
13. FATHER'S NAME UNKNOWN HENRY J. Gillis			14. MOTHER'S MAIDEN NAME EDNA DASHIELL		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO		17. INFORMANT Address EASTERN SHORE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) ASPIRATION OF VOMITUS DUE TO (c) CHRONIC CONGESTIVE HEART FAILURE					INTERVAL BETWEEN ONSET AND DEATH 5 MIN. 7 MIN. 5 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) PNEUMONIA					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 09-30 , 19 67 , to OCT 7 , 19 67 , that (I) (we) last saw the deceased alive on OCT 7 , 19 67 , and that death occurred at 125 PM , from causes and on the date stated above.					
22a. SIGNATURE Sean M. Killoran			22b. DATE SIGNED OCT. 7, 1967		
22c. PHYSICIAN'S NAME (Type) SEAN M. KILLORAN M.D.			22d. ADDRESS EASTERN SHORE STATE HOSPITAL		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-10-1967	23c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery	23d. LOCATION (City or Town) (County) (State) Mardela, Maryland		
24. FUNERAL DIRECTOR Thomas F. Wallace			25a. RECEIVED BY REGISTRAR DATE OCT 11 1967		
25b. REGISTRAR'S SIGNATURE Thomas F. Wallace					

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13809

13814

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Md. Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Dor. Ken c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge/ Millington, Md. d. STREET ADDRESS Glasgow Nursing Home/ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rolland L. Gundlach		4. DATE OF DEATH Oct. 29, 1967	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/1/99
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Iowa	
13. FATHER'S NAME Herman L.C. Gundlach		14. MOTHER'S MAIDEN NAME Unknown Nellie I. Bisby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown No.		16. SOCIAL SECURITY NO. ?	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia DUE TO (b) Fracture neck r. femur DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 3 days 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell out of bed.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11 AM 10/23/67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing Home		20f. (City or town) (County) (State) Cambridge Dor. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Maee Jr.		22. DATE SIGNED 10/29/67	
EXAMINER'S NAME (Type) John Maee Jr.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 1, 1967	23c. NAME OF CEMETERY OR CREMATORY Sudlersville Cemetery	23d. LOCATION (City, town or county) (State) Sudlersville, Q.A.Co; Md.
24. FUNERAL DIRECTOR Edward Fellows & Son,		25a. REC'D BY REGISTRAR 10/31/1967	
ADDRESS Millington, Md. 21651		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

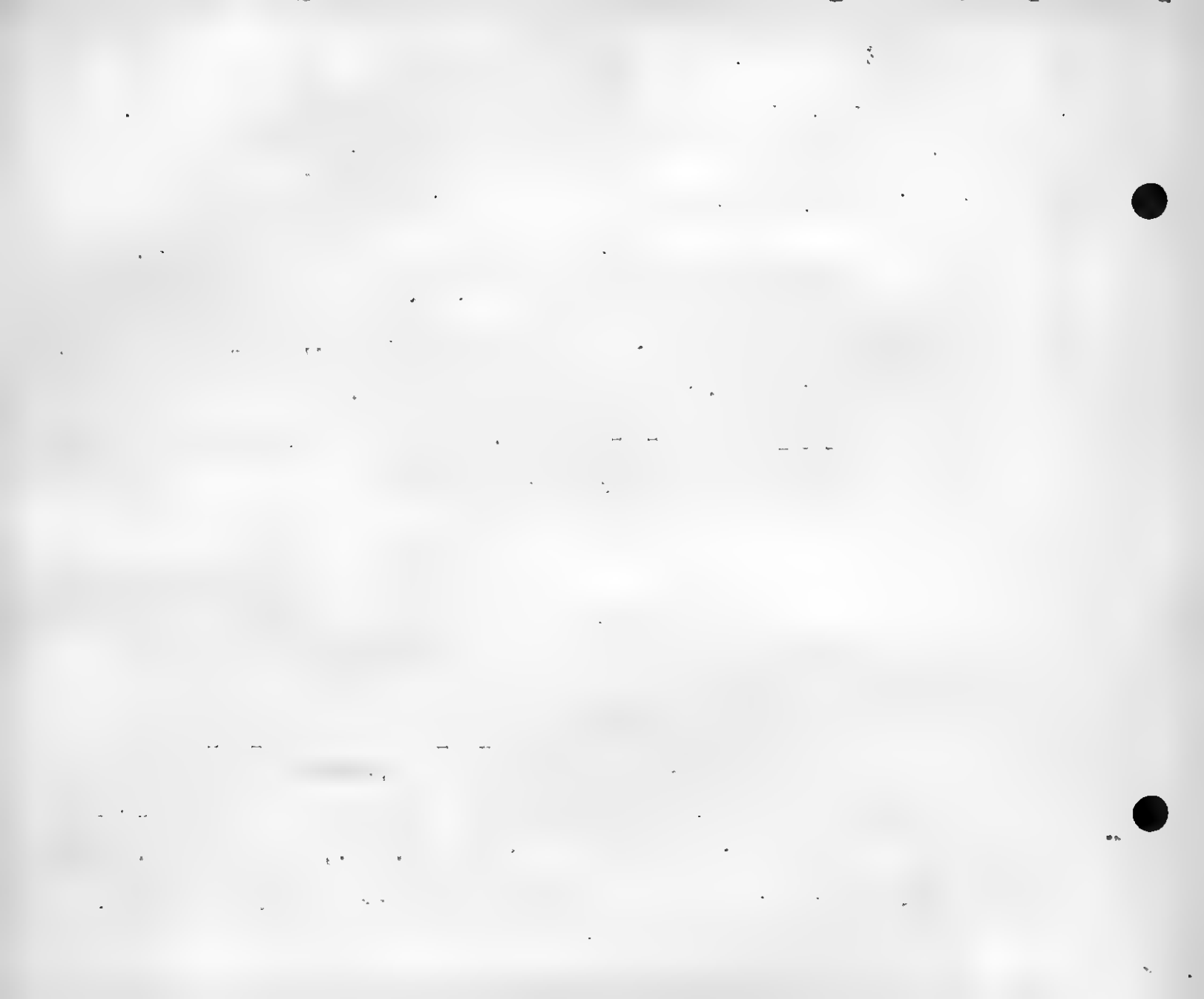
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dor.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>	
c. LENGTH OF STAY IN 1b <u>All Life</u>		d. STREET ADDRESS <u>Main</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>_____</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mark</u> Middle <u>Rosalin</u> Last <u>Helsbier</u>		4. DATE OF DEATH Month <u>10</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/24/1888</u>
9. AGE (in years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>_____</u> Days <u>_____</u> Hours <u>_____</u> Min. <u>_____</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework - Own Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>_____</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eben Wheatley</u>		14. MOTHER'S MAIDEN NAME <u>Huldah Cootee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT <u>Mrs. William Smith, Baltimore, Md.</u>		Address <u>_____</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Distention c Ventricular</u> 7744 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Congestive Heart Disease</u> DUE TO (c) <u>Arteriosclerotic Cardio Renal Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>3 mos</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>_____</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/25</u> , 19 <u>47</u> , to <u>10-1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/20</u> , 19 <u>67</u> , and that death occurred at <u>_____</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Harold B. Plummer</u> M.D.		22b. DATE SIGNED <u>10/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harold B. Plummer</u>		22d. ADDRESS <u>Preston Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/4/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		23d. LOCATION (city, town or county) (State) <u>East New Market Md</u>	
24. FUNERAL DIRECTOR <u>Arthur D. Mullonghby</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>East New Market</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>OCT 9 1967</u>			

CERTIFICATE OF DEATH

13816

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b about 45 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital		d. STREET ADDRESS 405 Must Street	
3. NAME OF DECEASED (Type or print) First LILLIAN Middle MAY Last HUBBARD		4. DATE OF DEATH Month Oct. Day 25 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1885
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William M. Reed		14. MOTHER'S MAIDEN NAME Ellen M. Paul	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-20-7533A	
17. INFORMANT Mr. Eldridge Hubbard, Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Hypertensive Cardio Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Arthritis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-11-61 19 to 10-25-67 19 , that (I) (we) last saw the deceased alive on 10-24-67 19 , and that death occurred 7:20AM from the causes and on the date stated above.			
22a. SIGNATURE <i>Albert E. Bunker</i>		22b. DATE SIGNED 10-27-67	
22c. PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M. D.		22d. ADDRESS 200 Md.Ave., Cambridge, Md. 21613	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 29, 1967	
23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City, town or county) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR OCT 30 1967	
25b. REGISTRAR'S SIGNATURE <i>James J. Jones</i>			



13812

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>2. A. Co</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Centerville</u>	
c. LENGTH OF STAY IN 1b <u>3 yrs</u>		d. STREET ADDRESS <u>Chesterfield Ave,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Martha Covey Hunter</u>		4 DATE OF DEATH Month <u>10</u> Day <u>- 11</u> Year <u>19 67</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>09-25-74</u> 89 yrs
9 AGE (In years last birth day) <u>89</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Robert Davis</u>		14. MOTHER'S MAIDEN NAME <u>SARAH DAVIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>21A-24-4761-J1</u>	
17. INFORMANT <u>E.S.S.H - Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Senile Cachexia</u>			
DUE TO (b) <u>177x</u>			
DUE TO (c) <u>4 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-09</u> , 19 <u>67</u> , to <u>10-11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-11</u> 19 <u>67</u> , and that death occurred at <u>1 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Efrain C. Fernandez</u> M.D.		22b. DATE SIGNED <u>10-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EFRAIN C. FERNANDEZ</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Oct. 14, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Centerville P. A. Co. Md.</u>
24. FUNERAL DIRECTOR <u>James H. Porter Jr. - Porter Bros., Centerville, Md.</u>		25a. READ BY REGISTRAR <u>DATE OCT 16 1967</u>	25b. REGISTRAR'S SIGNATURE <u>James H. Porter Jr.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13818				13818			
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY in 1b <u>1 Day</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge-Maryland Hospital</u>				d. STREET ADDRESS <u>308 Shepherd Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Major</u> Middle <u>Allen</u> Last <u>Hurley</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>30</u> Year <u>1967</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1878</u>		9. AGE (in years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester Co., Near Vienna U.S.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas Hurley</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Horseman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>513 Shepherd Ave.</u> <u>Mrs. W. Walton Fitzhugh, Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>Indefinite</u>	
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-29</u> , 19 <u>67</u> , to <u>10-30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-30</u> , 19 <u>67</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard G. Bilodeau</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-31-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD G. BILODEAU</u>				22d. ADDRESS <u>CITY OFFICE BLDG., CAMBRIDGE, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 2, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park Cambridge</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>Levin R. Thomas</u>		ADDRESS <u>Cambridge</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1000. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

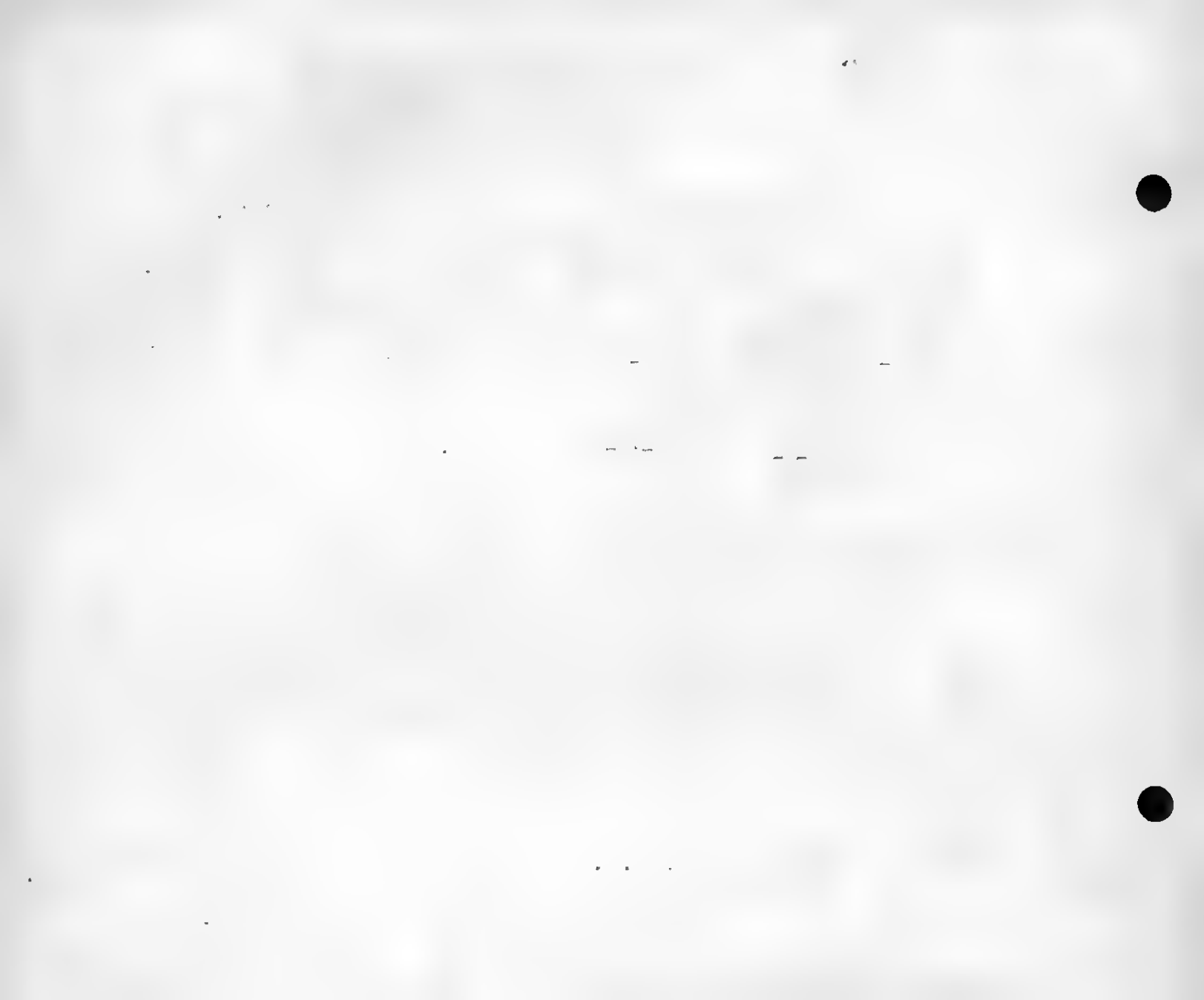
VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13819

1. PLACE OF DEATH a COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Dorchester	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	c LENGTH OF STAY IN 1b 10 years	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		d STREET ADDRESS 1003 Hambrooks Blv'd.	
3. NAME OF DECEASED (Type or print) JOHN HERMAN INSLEY		4. DATE OF DEATH Month Oct. Day 26 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1885
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-Waterman Ret.		10b. KIND OF BUSINESS OR INDUSTRY Dirt-Seafood	
11. BIRTHPLACE (State or foreign country) Toddville, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Hutz Insley		14. MOTHER'S MAIDEN NAME Elizabeth Rebecca Lloyd	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-16-8866	
17. INFORMANT Mrs. J. Herman Insley, Cambridge, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		22. DATE SIGNED 10/27/67	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		Address (Street, city, town, or county) Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct 28, 1967	23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park	23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR OCT 30 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	



13815

CERTIFICATE OF DEATH

13820

1 PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN ib Hurlock	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Maryland Hospital, Inc.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Lesia Ann Johnson		4 DATE OF DEATH Month Day Year October 19 19 67	
5 SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH October 19, 1967
9 AGE (n years last birthday) yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min. 13 47
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Dorchester; Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Winfield Johnson		14. MOTHER'S MAIDEN NAME Betty Maxnice Spry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother		Address Hurlock, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory distress syndrome DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his hospital) attended the deceased from 10-19-67 8:42 a.m. to Oct 19 1967 4:47 a.m. , that (I) (we) last saw the deceased alive on Oct 19 1967 , and that death occurred at 10:42 P.M. from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 10-20-67	
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett		22d. ADDRESS 623 High Street; Cambridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-21-67	23c. NAME OF CEMETERY OR CREMATORY Federalsburg, cemetery	23d. LOCATION (City or Town) (County) (State) Federalsburg
24. FUNERAL DIRECTOR Frampton		25a. REC'D BY REGISTRAR OCT 24 1967	25b. REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

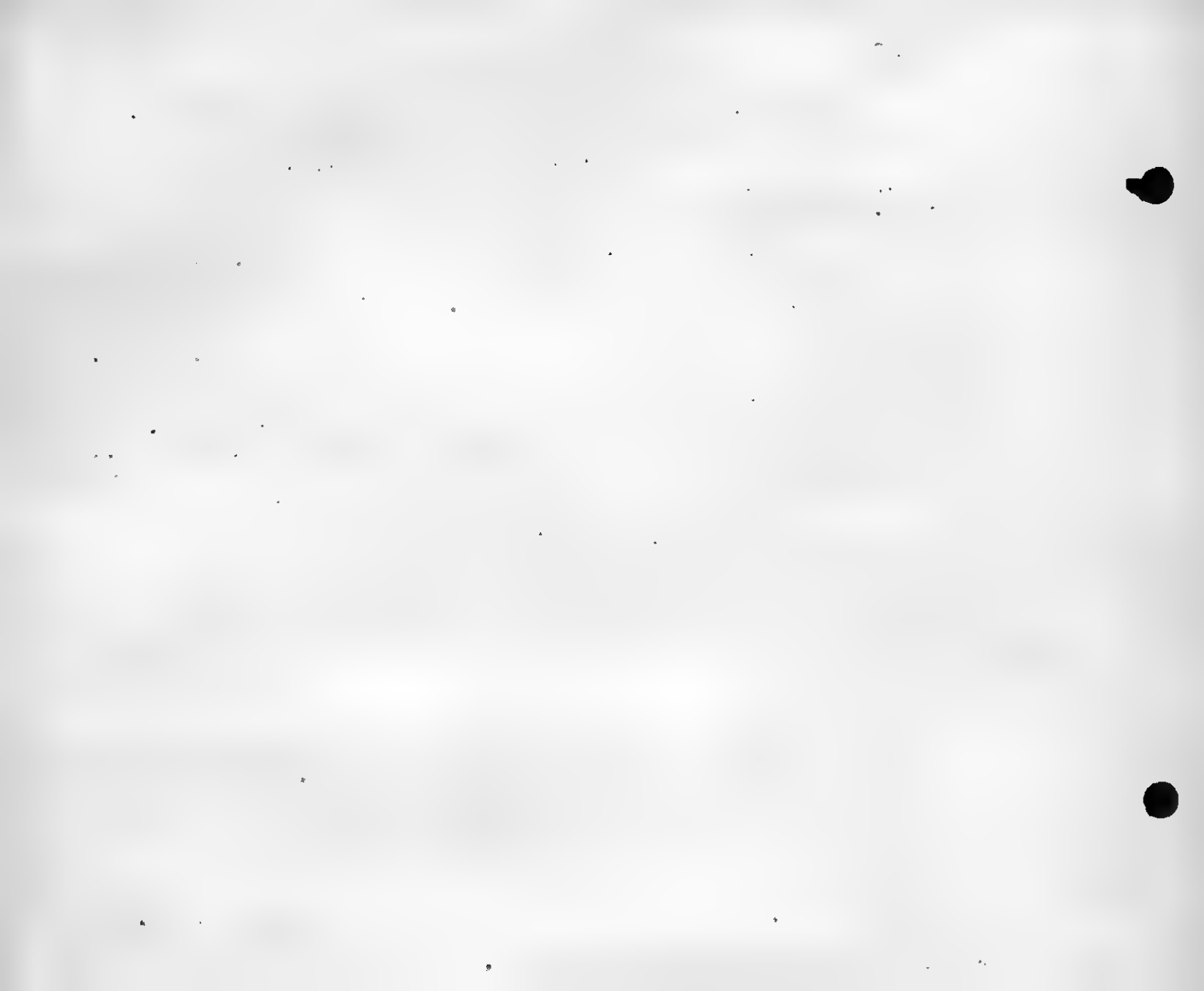
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR #15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 6 months		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Toddville,					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Maryland Hospital						d. STREET ADDRESS Rural				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grace Middle Insley Last Jones						4. DATE OF DEATH Month Oct. Day 13 Year 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 27, 1883		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Crapo, Dorchester Co., U.S.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Corbin Insley						14. MOTHER'S MAIDEN NAME Arianna Mister					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Cambridge, Md. W. Paul Jones, 10 Bellevue Ave.,					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastroenteritis										INTERVAL BETWEEN ONSET AND DEATH 120 minutes	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-11 , 19 67 , to 10-13 , 19 67 , that (I) (we) last saw the deceased alive on 10-9 , 19 67 , and that death occurred at 4:30 P. from the causes and on the date stated above.											
22a. SIGNATURE Richard D. Bilodeau						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) RICHARD D. BILODEAU						22d. ADDRESS CITY OFFICE BLVD.		22b. DATE SIGNED 10-16-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 15, 1967		23c. NAME OF CEMETERY OR CREMATORY Jones Family Cemetery		23d. LOCATION (City, town or county) (State) Toddville, Md.					
24. FUNERAL DIRECTOR Harrold R. Thorne						ADDRESS Cambridge, Md.		25a. RECD BY REGISTRAR OCT 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



1
FOR STATE HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13822

1 PLACE OF DEATH a COUNTY Dorchester MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institut on Residence before admission) a. STATE Maryland b COUNTY Dorchester	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c LENGTH OF STAY N Ib life	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital		e STREET ADDRESS 622 High St.	
3 NAME OF DECEASED (Type or print) Oliver Meekins		4 DATE OF DEATH Month October Day 29 Year 19 67	
5. SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10/9/1904
9 AGE (In years last birthday) 63 yrs		F UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Maryland		12 C TIZEN OF WHAT COUNTRY? USA	
13. EATHER'S NAME Charles Meekins Sr.		14 MOTHER'S MAIDEN NAME Emma Chester	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 214-07-9447	
17 INFORMANT Emma Wilson		Address Cambridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive cerebral hemorrhage DUE TO Cond. tions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 11/2/67 Address (Street, city, town, or county) Cambridge, Md.	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11/2/67	
23c NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		23d LOCATION (City or Town) (County) (State) Golden Hill, Dor., Md.	
24 FUNERAL DIRECTOR St. Clair Funeral		25a REC'D BY REGISTRAR NOV 6 1967	
ADDRESS Cambridge, Md.		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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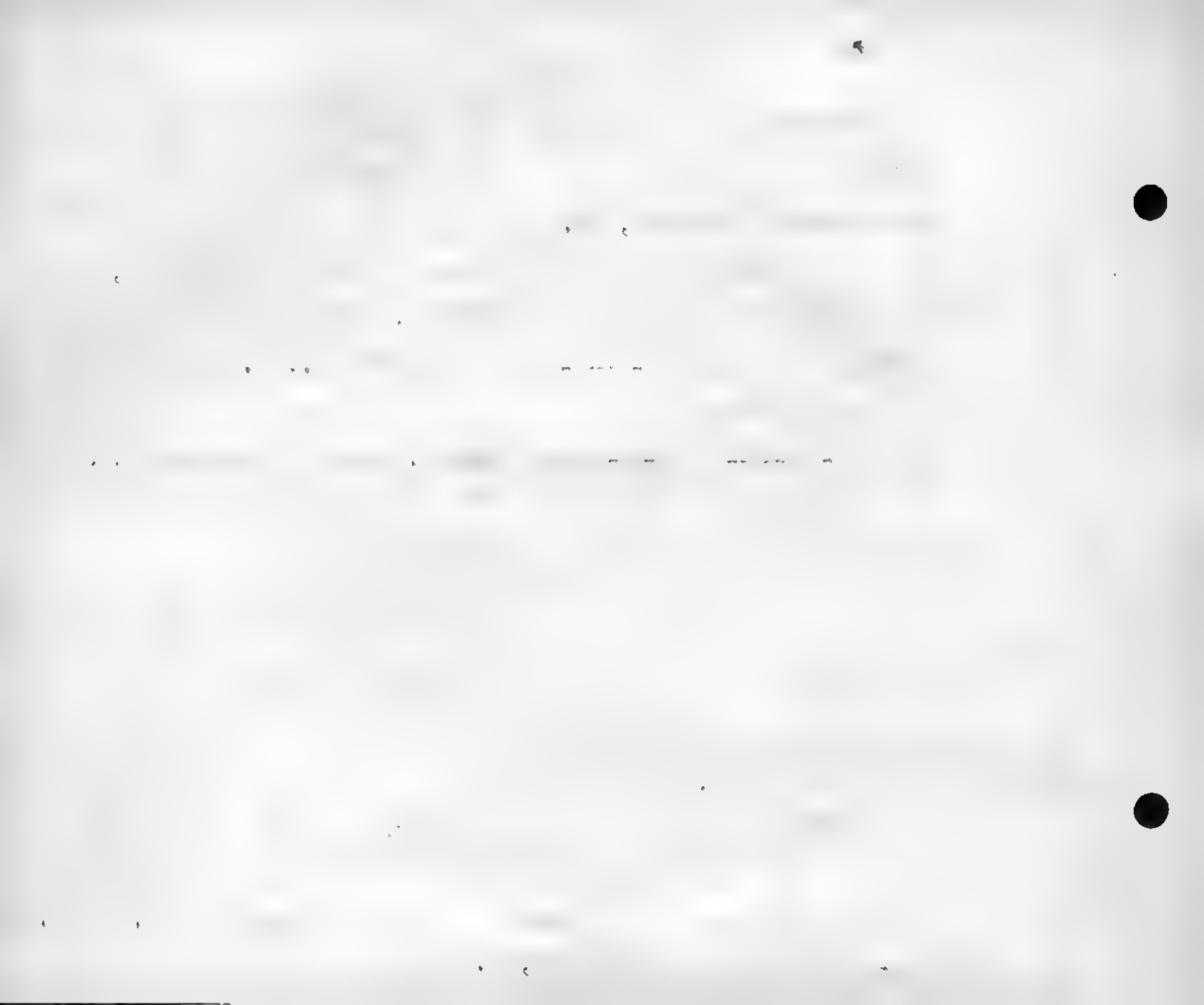
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13823

1 PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 15 HURLOCK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CAMBRIDGE MARYLAND HOSPITAL, INC.		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) GEORGE First Middle Last		4. DATE OF DEATH OCTOBER 4, 1967 Month Day Year	
5 SEX MALE	6. COLOR OR RACE NEGROID	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MARCH 14, 1889 9 AGE (In years last birthday) 78 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY -----	11 BIRTHPLACE (County & State, or foreign country) DORCHESTER CO., MD.
13. FATHER'S NAME HENRY MURRAY		14. MOTHER'S MAIDEN NAME MARY MURRAY	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 215-18-14657A	17. INFORMANT Address THELMA M. CORNISH WASHINGTON, D.C.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIAC DECOMPENSATION DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from Sept. 27, 1967 , to OCT. 4, 1967 , that (I) (we) saw the deceased alive on OCT. 3, 1967 , and that death occurred at ----- M, from causes and on the date stated above.			
22a. SIGNATURE <i>J. Edwin Fasset</i>		22b. DATE SIGNED OCT. 5, 1967	
22c. PHYSICIAN'S NAME (Type) J. EDWIN FASSETT, M.D.		22d. ADDRESS 623 High Street, Camb., Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 10/7/67	23c NAME OF CEMETERY OR CREMATORY Salem	23d LOCATION (City or Town) (County) (State) SALEM DOR. MD.
24. FUNERAL DIRECTOR <i>Julius C. Delair</i>		25a REC'D BY REGISTRAR DATE OCT 11 1967	25b REGISTRAR'S SIGNATURE <i>John C. Delair</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
CERTIFICATE OF DEATH			
13819			
13824			
1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN lb 15 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CAMBRIDGE MARYLAND HOSPITAL, INC.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HURLOCK	
3. NAME OF DECEASED (Type or print) First VERA Middle HOPKINS Last MURRAY		4. DATE OF DEATH Month OCTOBER Day 16 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE NEGROID	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 13, 1891 9. AGE (In years last birthday) 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) DORCHESTER CO., MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRISON HOPKINS		14. MOTHER'S MAIDEN NAME ELIZBETH BANKS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO *****		16. SOCIAL SECURITY NO. 220-01-7852A	
17. INFORMANT THELMA H. CORNISH		Address WASHINGTON, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Uremia DUE TO (b) Arteriosclerotic cardiovascular renal disease DUE TO (c) Arteriosclerotic cardiovascular renal disease			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 29, 1967 to Oct. 16, 1967 (that (I) (we) last saw the deceased alive on October 10, 1967 , and that death occurred at 10:19 M, from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED Oct. 17, '67	
22c. PHYSICIAN'S NAME (Type) EDWIN FASSETT, M.D.		22d. ADDRESS 623 HIGH STREET, CAMB., MD.	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/20/67	23c. NAME OF CEMETERY OR CREMATORY SALEM	23d. LOCATION (City or Town) (County) (State) SALEM DOR. MD.
24. FUNERAL DIRECTOR <i>[Signature]</i>		25a. REC'D BY REGISTRAR DATE NOV 6 1967	
ADDRESS CAMBRIDGE, MD.		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13820

13820

1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND <input checked="" type="checkbox"/>				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c. LENGTH OF STAY IN It <u>3 months</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Easton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Lumpkin Nelson</u>				4. DATE OF DEATH Month Day Year <u>10 9 1967</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-05-1882</u>	
9. AGE (In years last birthday) yrs <u>84</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garment Business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garment Business</u>		11. BIRTHPLACE (County & State or foreign country) <u>MARYLAND - U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John T. Nelson</u>				14. MOTHER'S MAIDEN NAME <u>Emma Lumpkin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>278-07-6098</u>		17. INFORMANT Address <u>Eastern Shore State Hosp. (Medical Records)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO 475X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED ARTERIOSCLEROSIS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 6</u> , 19 <u>67</u> , to <u>OCT 9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>OCT 9</u> , 19 <u>67</u> , and that death occurred at <u>4 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Sean M. Killoran MD</u> MD				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>OCT 9, 1967</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, or other disposition <u>Burial</u>		23b. DATE THEREOF <u>10/11/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Park</u>		23d. LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Marvise L. Deeney-Son Easton, Md</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove captop papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
13826									
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 19 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Cambridge d. STREET ADDRESS Paw Paw RFD No. 3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First KATHERINE Middle COLLINS Last NIEMAN					4. DATE OF DEATH Month Oct. Day 6 Year 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1880		9. AGE (In years last birthday) 87 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home			11. BIRTHPLACE (County & State, or foreign country) St. Michaels, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Collins					14. MOTHER'S MAIDEN NAME Johanna Pfister				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 208-01-6723D			17. INFORMANT Address Miss Mildred Nieman, RFD 3, Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma (adeno) of right colon with metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) colon with metastases DUE TO (c) months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from July , 19 67 , to Oct 6 , 19 67 , that (I) (we) last saw the deceased alive on Oct 6 , 19 67 , and that death occurred at 9 PM , from the causes and on the date stated above.									
22a. SIGNATURE Lewis M. Burdette 22c. PHYSICIAN'S NAME (Type) Lewis M. Burdette					22b. DATE SIGNED 9 Oct 67 22d. ADDRESS 4 Aurora St, Cambridge Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Oct 9, 1967		23c. NAME OF CEMETERY OR CREMATORY Old Trinity Cemetery		23d. LOCATION (City, town or county) (State) Church Creek, Maryland		
24. FUNERAL DIRECTOR ADDRESS LeCompte Funeral Service, Cambridge, Maryland					25a. REC'D BY REGISTRAR DATE OCT 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13822

13822

1. PLACE OF DEATH a COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE Maryland b COUNTY Dorchester	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c LENGTH OF STAY IN 1b 5 yrs.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Cambridge Md. Hospital		e STREET ADDRESS 12 Lincoln Terrace	
3. NAME OF DECEASED (Type or print) Eddie James Patterson		4. DATE OF DEATH Month Oct. Day 15 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/9/1938
9. AGE (In years last birthday) 29 yrs		10. IF UNDER 1 YEAR Months 2 Days 15 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ed. Patterson		14. MOTHER'S MAIDEN NAME Ida Watkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 219-46-0615	
17. INFORMANT Frances Fletcher		Address Cambridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-abdominal hemorrhage DUE TO (b) Shot gun wound abdomen c) Instant Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Instant			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Shot by shotgun (Homicide)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot by shotgun (Homicide)	
21a. TIME OF INJURY Month Day Year Hour a.m. 7:30PM 10/15/67	21b. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	21c. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Street	21d. (City or town) (County) (State) Cambridge Dor. Md.
21. I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr. EXAMINER'S NAME (Type) John Mace Jr.		22. DATE SIGNED 10/19/67	
23a. BURIAL, CREMATION, REMOVAL, SPECIFY Burial		23b. DATE THEREOF 10/21/67	
23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City or Town) (County) (State) Cambridge, Dor. Md.	
24. FUNERAL DIRECTOR Fredrick C. DeBair		ADDRESS Cambridge, Md.	
25a. REC'D BY REGISTRAR DATE OCT 24 1967		25b. REGISTRAR'S SIGNATURE John Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-15 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13828

1 PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY Dorchester	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cambridge		c LENGTH OF STAY IN IL Life	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD #3		e STREET ADDRESS RFD. #3	
3 NAME OF DECEASED (Type or print) Nicie Woolford Payne		4 DATE OF DEATH Oct. 8, 1967	
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 12, 1903
9 AGE (In years last birthday) 63 yes		FUNDING YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b KIND OF BUSINESS OR INDUSTRY ---	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Joseph Woolford		14 MOTHER'S MAIDEN NAME Catherine Dorsey	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 214-07-9443	
17 INFORMANT Gladys Palmer		Address Baltimore, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture cerebral aneurysm DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH Instant
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		22. DATE SIGNED 10/13/67	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		Address (Street, city, town, or county) Cambridge, Md.	
23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE THEREOF 10/12/67	23c NAME OF CEMETERY OR CREMATORY Christ Rock,	23d LOCATION (City or Town) (County) (State) Dorchester County, Md
24 FUNERAL DIRECTOR Charles C. Judge		25a REC'D BY REG. STRAR OCT 17 1967	
Address Cambridge, Md.		25b REG. STRAR'S SIGNATURE Charles Judge	

13829

FOR STATE
HEALTH DEP

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M ' 67

1 PLACE OF BIRTH a. COUNTY Dorchester MARYLAND		2 USUAL RESIDENCE (Where deceased lived if insttution Reside before arrival) a STATE Maryland b. COUNTY Dorchester	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cambridge	c LENGTH OF STAY IN lb	c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Rural Church Creek	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		e STREET ADDRESS	f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) Rómie Phillips		4 DATE OF DEATH Month Oct. Day 7 Year 1967	
5 SEX Male	6 COLOR OR RACE Nogrp	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 3, 1898
9 AGE (In years last birthday) yrs 69		10 IF UNDER YEAR MONTHS 69	11 IF UNDER 24 HRS Hours Min 69
10a USUA OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? USA			
13 FATHER'S NAME Hoseph Phillips		14 MOTHER'S MAIDEN NAME Eliza Travers	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16 SOCIAL SECURITY NO. 212-16-7374	17 INFORMANT Address Rachel Phillips Church Creek, Md.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 30 Mins.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1B)		
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, bag, etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr. EXAMINER'S NAME (Type) John Mace Jr., M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) Cambridge, Md.		22. DATE SIGNED 10/11/67
23a BURIAL CREMATION REMOVAL (Specify) Burial	23b DATE THEREOF 10/11/67	23c NAME OF CEMETERY OR REPOSITORY Linus Road Cemetery	23d LOCATION (City or Town) (County) (State) Dorchester Co., Md.
24 FEDERAL DIRECTOR William C. Shaw ADDRESS Cambridge, Md.		25a REC'D BY REGISTRAR DATE OCT 17 1967	25b REGISTRAR'S SIGNATURE Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13825

13830

1 PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
c. LENGTH OF STAY IN TB 50 Years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Zion Methodist Church		d. STREET ADDRESS 404 Linden Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Helen Daisy Ralph		4. DATE OF DEATH Month Day Year Oct. 29, 1967 19	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1885
9 AGE (in years last birthday) 82 yrs		10. FUNERAL 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Laurel, Del		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James L. Ralph		14. MOTHER'S MAIDEN NAME Ruth Goslee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH Instant			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		22. DATE SIGNED 10/30/67	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		Address (Street, city, town, or county) Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Nov. 1, 1967	23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park Cambridge, Md.	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR James R. Thorne		25a. REC'D BY REGISTRAR NOV 6 1967	
ADDRESS Cambridge, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (5)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13826

CERTIFICATE OF DEATH

13831

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE	
b. CITY OR TOWN (If outside corporate limits, write RURAL) CHESTER (RURAL)		c. LENGTH OF STAY IN 1b 2 MONTHS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS Box 24A	
3. NAME OF DECEASED (Type or print) ESTHER L RANKIN		4. DATE OF DEATH Month OCTOBER Day 3 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03-15-30
9. AGE (In years birthday) 37 yrs		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JORDAN RANKIN		14. MOTHER'S MAIDEN NAME ANNA TAYLOR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT RECORDS OF THE EASTERN SHORE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) 2 hours. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Post-pancreatectomy diabetes - Bowel fistula, post-operative			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. ((City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred on _____ M, from causes and on the date stated above.			
22a. SIGNATURE E. Fernandez		22b. DATE SIGNED OCT. 4 1967	
22c. PHYSICIAN'S NAME (Type) EFRAIN C. FERNANDEZ		22d. ADDRESS E.S.S. Hospital	
23a. BURIAL (CREMATON, REMOVAL) (Specify) BURIAL		23b. DATE THEREOF 10/9/67	
23c. NAME OF CEMETERY OR CREMATORY UNION		23d. LOCATION (City or Town) (County) (State) CHESTER KENT MD.	
24. FUNERAL DIRECTOR John C. [Signature]		25a. REC'D BY REGISTRAR OCT 11 1967	
ADDRESS CAMBRIDGE, MD.		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

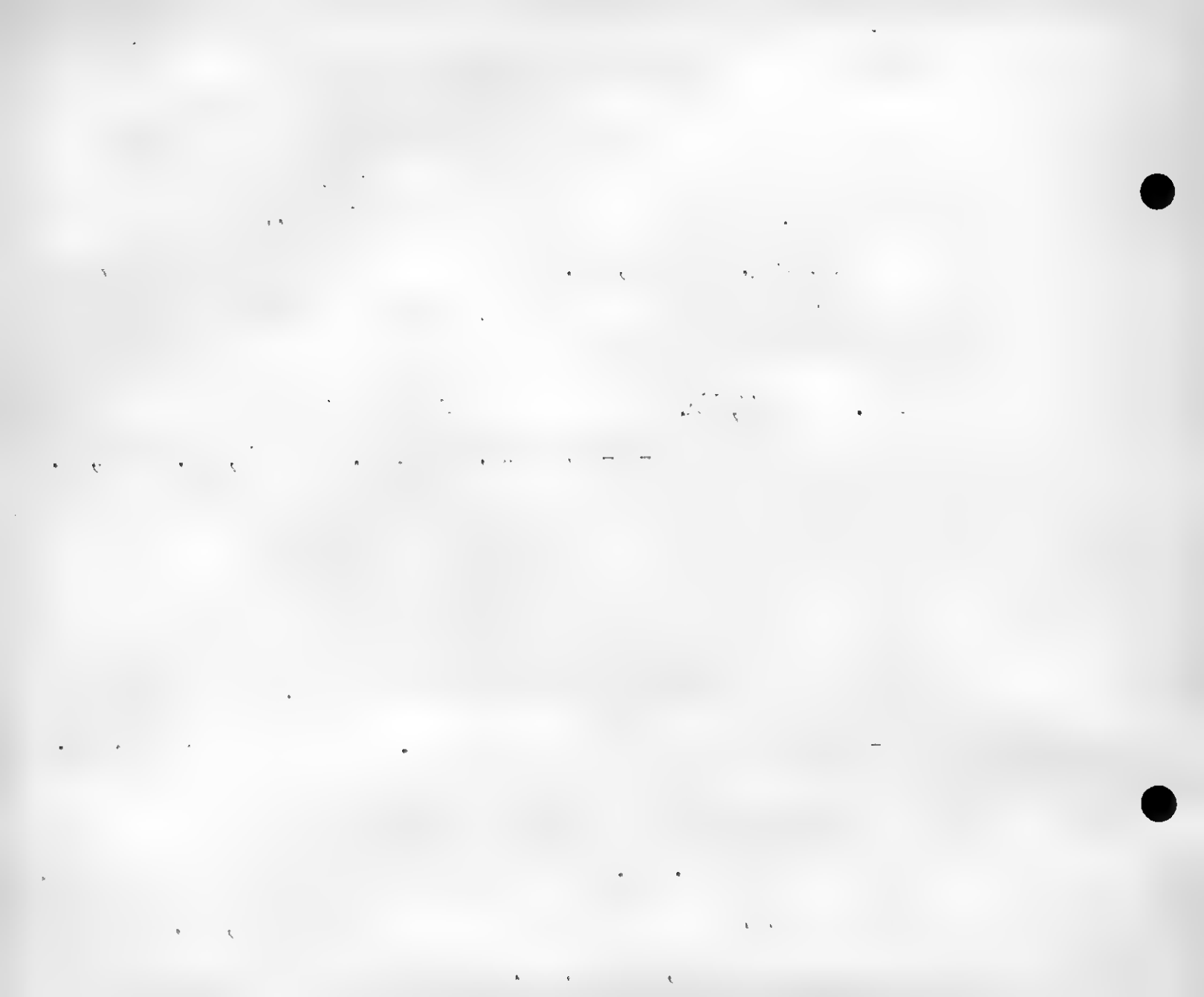
VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13832

1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>205 Davis Ave.,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Curtis C. Satchell, Jr.</u>		4 DATE OF DEATH Month <u>10/1</u> Day <u>1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10/11/1920</u>
9 AGE (In years and birthday) <u>46</u> yrs		IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar tender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Club</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		2 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Curtis C. Satchell, Sr.</u>		14 MOTHER'S MAIDEN NAME <u>Elizabeth Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>218-20-6049</u>	
17 INFORMANT <u>Mrs. Curtis C. Satchell, Jr.</u>		Address <u>Easton, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra abdominal hemorrhage</u> DUE TO (b) <u>825.4</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Driver of auto which hit pole.</u>	
20c. TIME OF INJURY Month, Day, Year Hour am <u>2:30</u> <u>10/1/67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Glasgow St.</u>	20f. (City or town) (County) (State) <u>Cambridge, Dor. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>John Mace Jr. Md.</u>		22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MED. CA. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/3/67</u> Address (Street, city, town, or county) <u>Cambridge, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/4/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Easton, Md.</u>
24 FUNERAL DIRECTOR <u>MAURICE E. NEWMAN & SON, Easton, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 5 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
CERTIFICATE OF DEATH			
138333			
1. PLACE OF DEATH a COUNTY Dorchester b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Dorchester c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) East New Market - Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital		d. STREET ADDRESS R.F.D. #1	
3. NAME OF DECEASED (Type or print) First CARRIE Middle SIMMONS Last SIMMONS		4 DATE OF DEATH Month October Day 8 Year 19 67	
5 SEX Female	6 COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1922
9 AGE (In years lost birthday) 45 yrs		IF UNDER 1 YEAR Months 45 Days 45 Hours 45 Min 45	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11 BIRTHPLACE (County & State, or foreign country) Lenore County, N.C.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Broadie Whitfield		14. MOTHER'S MAIDEN NAME Narcissus Joyner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 239-16-6313	
17. INFORMANT Frank Simmons, East New Market, Md., RFD #1		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia DUE TO Hypertensive Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Arteriosclerotic cardiovascular renal disease (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from Sept. 22, 1967 , to Oct. 6, 1967 , that (I) (we) last saw the deceased alive on Oct. 3, 1967 , and that death occurred at 3 P.M. , from causes and on the date stated above.			
22a SIGNATURE <i>J. Edwin Fassett</i>		22b. DATE SIGNED Oct. 10, 1967	
22c. PHYSICIAN'S NAME (Type) J. EDWIN FASSETT, M.D.		22d ADDRESS 623 High Street, Camb., Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF October 14, 1967	23c NAME OF CEMETERY OR CREMATORY Rhodesdale Cemetery	23d LOCATION (City or Town) (County) (State) Near Rhodesdale, Md.
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Md.		25a REC'D BY REGISTRAR OCT 20 1967	
25b REGISTRAR'S SIGNATURE <i>O'Connell Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsburg - Rural c. LENGTH OF STAY IN TB 8 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLYDE First Middle Last SPENCER		4. DATE OF DEATH Month Day Year October 26 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1900
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Retired Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory	
11. BIRTHPLACE (County & State, or foreign country) Valdosta, Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Times Spencer		14. MOTHER'S MAIDEN NAME Lena Nathan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO 364-20-1015	
17. INFORMANT Mrs. Lena Spencer, Coraopolis, Penna.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Cardiac Congestive failure DUE TO (b) Hypertensive Arteriosclerotic heart Disease 10yrs DUE TO (c) Arteriosclerosis Generalized 20yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilaterally Blind		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/27/67 , 19 67 , to 10/26/67 , 19 67 , that (I) (we) last saw the deceased alive on 10/23/67 , 19 67 , and that death occurred at 7 P.M. , from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 11/1/67	
22c. PHYSICIAN'S NAME (Type) Harold B. Plummer		22d. ADDRESS Preston Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 31, 1967	23c. NAME OF CEMETERY OR CREMATORY Washington Cemetery	23d. LOCATION (City or town) (County) (State) Near Hurlock, Maryland
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR NOV 6 1967	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. REGISTRAR'S NAME Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13830
13835
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN ID 2 days		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Md. Hospital			d. STREET ADDRESS Madison		
3. NAME OF DECEASED (Type or print) First Philip Middle Hamilton Last Travers			4. DATE OF DEATH Month October Day 8 Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1904	9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Dorchester Md.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Lake R. Travers			14. MOTHER'S MAIDEN NAME Mary Thomas		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-16-986	17. INFORMANT Mrs. P. Hamilton Travers Address Madison Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BLADDER DUE TO METASTASIS TO PELVIS & BOWEL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH 10 Mths.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from DEC 5, 1966 , to OCT 8, 1967 , that (I) (we) last saw the deceased alive on OCT 8, 1967 , and that death occurred at 10:26 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Alfred R. Maryanov			22b. DATE SIGNED 10/9/67		
22c. PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV			22d. ADDRESS 610 RACE ST CAMBRIDGE, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-11-67	23c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEM-PARK	23d. LOCATION (City, town or county) (State) CAMBRIDGE MD.		
24. FUNERAL DIRECTOR Anneth R. Thomas ADDRESS CAMBRIDGE MD.			25a. REC'D BY REGISTRAR DATE OCT 11 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

13831

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13836

1 PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Madison		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Madison			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None				d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last WILLIAM E. TREGOE				4 DATE OF DEATH Month Day Year Oct. 30, 1967			
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1893	9 AGE (In years last birthday) yrs 74	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-Lumberman		10b. KIND OF BUSINESS OR INDUSTRY Dirt-Timber		11 BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William L. Tregoe				14 MOTHER'S MAIDEN NAME Ida Gore			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I		16 SOCIAL SECURITY NO 220-16-9970		17 INFORMANT Harold Jones, 1553 Doxbury Road, Towson, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						9 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Mace Jr.		EXAMINER'S NAME (Type) John Mace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 11/2/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 2, 1967		23c. NAME OF CEMETERY OR CREMATORY Joppa Churchyard		23d. LOCATION (City or Town) (County) (State) Madison, Dor. Co., Maryland	
24 FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland				25a. REC'D BY REGISTRAR DATE NOV 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

3832

CERTIFICATE OF DEATH

13837

1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>	
c. LENGTH OF STAY IN 1b <u>240.9 mos 24 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u></u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Ethel Melinda White</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9, 1882</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Livi K. Amon</u>		14. MOTHER'S MAIDEN NAME <u>SARAH S. YMOORE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO <u>216-56-0753</u>	
17. INFORMANT <u>Med Records</u>		Address <u>Eastern Shore State Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PYELONEPHRITIS</u> DUE TO (c) <u>CHRONIC BRAIN SYNDROME</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 MO</u> <u>2 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIAPHRAGMATIC MEILITIS + ACUTE RIGIDOSIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 6</u> , 19 <u>67</u> , to <u>OCT 7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>OCT 7</u> , 19 <u>67</u> , and that death occurred at <u>6:20</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Sean M. Killoran</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Sean M. Killoran</u>		22d. ADDRESS <u>Cambridge Public Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Oct. 9, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	23d. LOCATION (City or town) (County) (State) <u>Easton</u> <u>Dorchester</u> <u>Md</u>
24. FUNERAL DIRECTOR <u>James J. Jones</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 13 1967</u>	25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>

1 1

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department at Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13834

1 PLACE OF DEATH a COUNTY Dorchester MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a STATE Maryland b COUNTY Talbot ✓	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c LENGTH OF STAY N 1b 10 Min.	c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Easton
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital		d STREET ADDRESS R.F.D. 2	
3 NAME OF DECEASED (Type or print) Joshua Wilkins Jr.		4 DATE OF DEATH Month 10 Day 5 Year 67	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 2, 1918
9 AGE in years (last birthday) yrs 49		F UNDER 1 YEAR Months Days Hours Min F UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b KIND OF BUSINESS OR INDUSTRY None	11 BIRTHPLACE (State or foreign country) Queen Anne Co., Md.
12 CITIZEN OF WHAT COUNTRY USA		13 FATHER'S NAME Joshua Wilkins	
14 MOTHER'S MAIDEN NAME Susie Harris		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO 213-24-1525		17 INFORMANT Dorothy Wilkins Rt.2, Box 241, Easton, Md.	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Grand Mal seizure #201 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) } DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 hour ?			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr. EXAMINER'S NAME Type		22. DATE SIGNED 10/8/67	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 10/12/67	23c NAME OF CEMETERY OR CREMATORY Carmicheal
23d LOCATION (City or Town) (County) (State) Queen Anne, Md.		23e LOCAL REGISTRATION OCT 11 1967	
24 FUNERAL DIRECTOR Dashiell Funeral Home, Easton, Maryland		25b REGISTRATION SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
13839											
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND b. COUNTY Talbot					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Cambridge, MD				c. LENGTH OF STAY IN 1b 9 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman - Rural					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN Shore State Hospital						d. STREET ADDRESS ---				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) S. HOWARD First Middle Last Willey						4. DATE OF DEATH Month 10 Day 25 Year 1967					
5. SEX M		6. COLOR OR RACE COL		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 06-24-89		9. AGE (In years last birthday) 78 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATER MAN				10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (County & State or foreign country) Neavitt, MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL Bush Willey						14. MOTHER'S MAIDEN NAME ELLA Willey					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO 218-10-6583 A		17. INFORMANT medical Record CHART Address E.S.S.H					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia due to aspiration of vomit DUE TO Cerebral vascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 5 days											
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.											
22a. SIGNATURE Felipe M. Dominguez M.D.						ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 10-26-67			
22c. PHYSICIAN'S NAME (Type) FELIPE M. DOMINGUEZ						22d. ADDRESS ESSH					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 10/27/1967		23c. NAME OF CEMETERY OR CREMATORY METHODIST				23d. LOCATION (City or Town) (County) (State) TILGHMAN, MD.	
24. FUNERAL DIRECTOR Marlene K. Newman						ADDRESS LA-tow, Md		25a. REC'D BY REGISTRAR DATE OCT 26 1967		25b. REGISTRAR'S SIGNATURE Charles J...	

13835

CERTIFICATE OF DEATH

13840

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY CAROLINE ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE			c. LENGTH OF STAY IN lb 1 WEEK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELY		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL				d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jacob First ROLLIE Middle WILLOUGHBY Last				4. DATE OF DEATH Month OCTOBER Day 6 Year 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/20/78		9. AGE (in years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ANDREW WILLOUGHBY				14. MOTHER'S MAIDEN NAME EMILY - Willoughby			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO 217-54-5731 J1		17. INFORMANT HOSPITAL RECORDS Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Chronic pyelonephritis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 days 1 year	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September 28, 1967 , to October 6, 1967 , that (I) (we) last saw the deceased alive on October 6, 1967 , and that death occurred at 2:45 AM, from causes and on the date stated above.							
22a. SIGNATURE Carlos F. Barros M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED October 6-67	
22c. PHYSICIAN'S NAME (Type) CARLOS F. BARROSO				22d. ADDRESS E.S.S. HOSPITAL, CAMBRIDGE, MD.			
23a. BURIAL, CREMATION, Burial		23b. DATE THEREOF 10-8-67		23c. NAME OF CEMETERY OR CREMATORY Greensboro		23d. LOCATION (City or Town) (County) (State) Greensboro, Maryland	
24. FUNERAL DIRECTOR J.C. Bouclair, Greensboro, Md.				25a. REC'D BY REGISTRAR DATE OCT 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

<div> <div>13836</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div>CERTIFICATE OF DEATH</div> <div>13841</div> </div>									
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b <u>33 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>125 Maryland Ave.</u>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> d. STREET ADDRESS <u>125 Maryland Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>Viola Tolley Windsor</u>			4. DATE OF DEATH Month Day Year <u>Oct. 8, 1967</u> 19		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 5, 1914</u> <u>Nov. 9, 1914</u> 9. AGE (In years last birthday) <u>52 yrs.</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> 10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Hoopersville, Dor. Co.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Coldsborough Tolley</u> 14. MOTHER'S MAIDEN NAME <u>Grace Phillips</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. 17. INFORMANT <u>George A. Windsor, Cambridge, Md.</u> Address <u>125 Maryland Ave.,</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHIOGENIC CARCINOMA</u> DUE TO <u>METASTASIS TO SPINE & PERICARDIUM</u> (b) _____ DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>AUG 21, 1967</u> to <u>OCT 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>OCT 6, 1967</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Alfred R. Maryanov</u>			22b. DATE SIGNED <u>10/9/67</u>		22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. MARYANOV</u> 22d. ADDRESS <u>610 RACE ST, CAMBRIDGE MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Oct. 10, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park, Cambridge, Md.</u>		23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR <u>Samuel D. Thoresen</u> ADDRESS <u>Cambridge, Md.</u>			25a. REC'D BY REGISTRAR <u>OCT 11 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Items 8 & 9 Film G392 11/21/67 KK											
CERTIFICATE OF DEATH											
13837											
13842											
1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>			c. LENGTH OF STAY IN 1b <u>4 mos. 8 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON (RURAL)</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTERN SHORE STATE HOSPITAL</u>					d. STREET ADDRESS <u>RT 1 Box 263</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edith</u> First <u>ROSELLE</u> Middle <u>WRIGHT</u> Last					4. DATE OF DEATH Month <u>10</u> Day <u>21</u> Year <u>1967</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-08-12A/1923</u>		9. AGE (In years last birthday) <u>42 1/4</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>TALBOT, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13. FATHER'S NAME <u>ELON WRIGHT</u>					14. MOTHER'S MAIDEN NAME <u>MARY D. WRIGHT</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>EASTERN SHORE STATE HOSPITAL</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA (LEFT LOWER LOBE)</u> <u>490x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) <u>SEIZURE DISORDER.</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 WK.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HURLER'S SYNDROME</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>06-15</u> , 19 <u>67</u> , to <u>OCT 21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>OCT 21</u> 19 <u>67</u> , and that death occurred at <u>7:30</u> A.M., from causes and on the date stated above.											
22a. SIGNATURE <u>Sean M. Killoran</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Oct 21, 1967</u>				
22c. PHYSICIAN'S NAME (Type) <u>SEAN M. Killoran</u>					22d. ADDRESS <u>EASTERN SHORE STATE HOSP.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>OCT 24, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DENTON</u>			23d. LOCATION (City or Town) (County) (State) <u>DENTON MD</u>				
24. FUNERAL DIRECTOR <u>CHARLES MOORE</u>					ADDRESS <u>DENTON</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Moore</u>		

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